Medical Records

Civil Action Number: 2:17-01146
Claimant: Trish Ann Fontana
Account Number: 197-56-3849

Exhibits

DATE: April 18, 2018

The documents and exhibits contained in this administrative record are the best copies obtainable.

ED Evaluation Note-Mercy:

University of Pittsburgh Medical Center

Patient: **FONTANA, TRISH A** **MRN: 980404528** **FIN: 0334426883107**
Age: **45 years** Sex: **Female** DOB: **6/2/1967**
Associated Diagnoses: **None**
Author: **CONOVER, KEITH**

Visit Information
Visit Information: Patient seen on 4/17/2013.

Findings

****
****
ATTENDING EMERGENCY MEDICINE NOTE:

Registration clerk chief complaint reviewed. Agree

Triage note reviewed. Agree

CHIEF COMPLAINT: Right neck pain, weakness in hands, tingling in the legs

History of Present Illness: The patient is a 45-year-old woman, smoker, past medical history of some chronic low back pain which is not a current complaint, did have surgery for an L5-S1 disc 2 years ago, also a history of about a year of undiagnosed rash on her right cheek despite seeing dermatology, here with a chief complaint of 2 weeks of progressive worsening of pain in the right more than left neck, associated with a decreased range of motion there, and some mild bilateral hand weakness, as well some intermittent tingling in both legs. No saddle anesthesia, no problems with urination or defecation. The pain is moderate, dull and aching. Does not want any pain medication for it at this time.

REVIEW OF SYSTEMS: All systems listed below were reviewed and are negative unless otherwise noted in the report.
General
EYES
ENT
Cardiac
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Dermatologic
Neurological
Allergic/Immunologic

PAST MEDICAL HISTORY: As above

MEDICATIONS: Reviewed and agree with Nursing Notes

ALLERGIES: Reviewed and agree with Nursing Notes

SOCIAL HISTORY: As above

PHYSICAL EXAM: Vital Signs: reviewed nurses' note
PATENT STATUS: alert, cooperative, mild distress, holding her neck quite still, not ill appearing, well-hydrated
EYES: PERRL, EOMI, no injection, anicteric.
THROAT: No injection. No exudate. No tonsillar hypertrophy. Airway widely patent. Uvula is midline. No tonsillar bulging, retropharyngeal soft tissues appear normal.
NECK: Range of motion is decreased. Moderate right more than left spasm but minimal tenderness. No palpable adenopathy. No midline tenderness.
BACK: No costovertebral, paravertebral, intravertebral or prevertebral tenderness or spasm.
CHEST: nontender, normal expansion, no retractions.
LUNGS: Clear to auscultation and percussion. No rales. No rhonchi. No rubs. No wheezes.
HEART: Regular rate and rhythm, no murmurs rubs or gallops.
ABDOMEN: Soft, nontender, normal bowel sounds, no guarding or rebound, no hepatosplenomegaly or mass, no bruit.

SKIN: Warm, dry, no cyanosis, no petechiae. There is a 4 cm circular erythematous lesion on the right cheek with some central fine scaling however no palpable adenopathy proximal to this.
EXTREMITIES: No edema. No cyanosis. No clubbing. No calf tenderness.
NEUROLOGICAL: Alert. Cooperative. Sensory and motor functions are intact except for some mild weakness of hand grip bilaterally, difficult to rate but probably a bit less than her normal.

MEDICAL DECISION MAKING/DIFFERENTIAL DIAGNOSIS: Old records reviewed. This scenario it is very concerning for possible spinal stenosis in the cervical spine, so obtained an MRI; no IVDA, no recent fever, no palpable adenopathy, not particularly suspicious of cancer or infection, so the MRI was without contrast. This did show a large herniated disc at C4-5 with indentation of the spinal cord. Given her symptoms, and this finding, I immediately contacted Dr. Blackrick on call for her orthopedic surgeon, Dr. Richman. We agreed on a Medrol Dosepak, Tylenol and Flexeril, and she will keep her appointment with him on Monday. Cautioned to return to ED if worse weakness in hands or any new or worsening symptoms. Recommended gentle neck stretching.

DIAGNOSIS: Acute herniated cervical disc with spinal stenosis and motor weakness in the hands.

DISPOSITION: Patient discharged in stable condition. Computer-generated discharge instructions provided.

Professional Services
Credentials Title and Author
Credentials: MD.
Title: Attending.

Perform - Completed by CONOVER, KEITH (on 04/17/2013 15:29)
Sign - Completed by CONOVER, KEITH (on 04/17/2013 15:29)
VERIFY - Completed by CONOVER, KEITH (on 04/17/2013 15:29)

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH A DOB: 06/02/1967

MRN: 980404528 Gender: F Location: UDEM (MCY)

Exam Desc: MR SPINE CERVICAL WITHOUT CONTRAST

Accession Date: 04/17/2013 13:29
Dictated on : 04/17/2013 15:37

Attending MD: KEITH CONOVER

Requesting MD: KEITH CONOVER

Accession #: 70217036 Visit Number: 0334426883107

Attending Interpreter: KHURSHED J DASTUR
Assisting Interpreter: BENJAMIN C JACOBS

*** FINAL REPORT ***

Reason for the Exam:
? cord compression: R neck pain 2 wks, weakness in hands, numbness in legs
CLINICAL HISTORY: 45-year-old woman with right neck pain and leg and arm weakness for 2 weeks.
TECHNIQUE:
Multiecho multiplanar MR imaging of the cervical spine was performed without intravenous contrast. Sequences include 3 plane localizer, sagittal T1, sagittal STIR, sagittal T2, axial T2 stack, axial gradient, and axial T1.
COMPARISON:
None.
FINDINGS:
There is mild straightening of the normal cervical lordosis and possible mild smooth kyphosis, centered at C4-C5. Bony alignment is anatomic and there is no evidence of acute fracture. Mild disc space narrowing is most significant at C5-C6. The craniocervical junction is unremarkable. Paravertebral soft tissues appear normal. Vertebral artery flow voids are preserved.
Degenerative changes are most significant at C4-C5 where a posterior disc osteophyte complex impresses upon and mildly distorts the ventral aspect of the cervical cord. There is no definite associated cord signal abnormality to suggest edema. The spinal canal and neural foramina are patent at all other imaged levels.
IMPRESSION:
Degenerative changes most significant at C4-C5 where a posterior disc osteophyte complex impresses upon and distorts the ventral aspect of the cord.
Degenerative narrowing of C5-6 disc space.
RELEVANT CLINICAL INFORMATION: ? cord compression: R neck pain 2 wks, weakness in hands, numbness in legs
Dictated by: KHURSHED J DASTUR
Signed by: KHURSHED J DASTUR
Signed on: 04/17/2013 at 3:37 PM

*U*P*M*C* FONTANA,TRISH Acct#:0334426881363

UPMC MERCY
PAIN SERVICE
OPERATIVE REPORT

PATIENT NAME: FONTANA, TRISH A
ACCOUNT #: 0334426881363
SURGEON: Gregg G. Weidner, M.D.
ATTENDING PHYSICIAN: GREGG WEIDNER
SURGERY DATE: 01/12/12
ADMISSION DATE: 01/12/2012
DISCHARGE DATE:

HISTORY:

Trish returns to see me. The patient complains of back pain with some tingling going down her legs. The patient denies any weakness. The patient had trialed the Neurontin which she does think it has been helpful, but she has been reluctant to take it _____ possible side effects. She has been taking Vicodin, but she has been out of Vicodin for some time. The patient today did undergo repeat lumbar epidural steroid injection which was well tolerated.

PROCEDURE NOTE:

With informed consent, the patient was placed in the prone position. ChloraPrep was applied in a wide and thorough prep. Then Betadine was applied. Sterile draping was utilized. Skin infiltration was performed with 5 mL of 1% lidocaine. Then under fluoroscopic guidance, an 18-gauge Tuohy needle was advanced into the interlaminar epidural plane. No heme or CSF was aspirated. Methylprednisolone was then drawn up sterilely and injected 80 mg in a volume of 2 mL preservative saline. Needle tract was cleared.

The patient tolerated this well. The patient was given a prescription for short supply of Vicodin. I discussed these issues thoroughly with patient.

_____
Authenticated electronically at end of document

Dictator: Gregg G. Weidner, M.D.

GGW/dn

D: 01/12/2012 09:40:32
T: 01/12/2012 17:26:15
R: 01/12/2012 17:26:15/dn
43436957/3833496/39750353

CC:

Authenticated by GREGG G WEIDNER, MD On 01/18/2012 07:13:57 AM

*U*P*M*C* FONTANA,TRISH Acct#:0334426881334

UPMC MERCY
PAIN SERVICE
OPERATIVE REPORT

PATIENT NAME: FONTANA, TRISH A
ACCOUNT #: 0334426881334
SURGEON: Gregg G. Weidner, M.D.
ATTENDING PHYSICIAN: GREGG WEIDNER
SURGERY DATE: 12/09/11
ADMISSION DATE: 12/09/2011
DISCHARGE DATE:

DATE OF BIRTH:

06/02/1967

HISTORY OF PRESENT ILLNESS:

Ms. Fontana is a very pleasant lady who presents to me at Dr. Richman's request. The patient has a history of a previous lumbar laminectomy at L5-S1 with Dr. Richman. In June 2011, she had the significant pain down the right leg at that time and was found to have a large disk herniation with compression of the S1 nerve root. She tolerated the surgery well and initially saw significant improvement in her leg pain, but now has seen persistent low back pain with some pain traveling into her legs, but not in the same fashion as it had prior to surgery. The patient also complains of some degree of neck pain and pain into the arms. She notes that activity seems to exacerbate her pain. She gets crampy in her legs. She feels shooting pain into the _____ feet. The patient cannot exercise for any significant length of time secondary to pain. She cannot sit for a long time. The patient has been taking Vicodin twice a day for the pain as well as ibuprofen and Prilosec. The patient has no bowel or bladder incontinence. She has had no falls, no trauma. The patient denies any headaches.

REVIEW OF SYSTEMS:

The patient's review of systems is otherwise negative aside from joint pains, stiffness, and muscle aches. Her review of system is negative for constitutive, visual, ear, nose, and throat, respiratory, cardiovascular, musculoskeletal, dermatologic, immunologic, hematologic, lymphangitic, genitourinary, gynecologic, psychiatric, and psychologic.

FAMILY HISTORY:

The patient's family history is significant for father having hypertension, diabetes, coronary artery disease and end-stage renal failure. Her mother has hypertension.

PAST SURGICAL HISTORY:

The patient's past surgical history includes:
1. Pilonidal cyst operation.

*U*P*M*C* FONTANA,TRISH Acct#:0334426881334
2. She has also had podiatric surgery in addition to lumbar spinal surgery.

ALLERGIES:

THE PATIENT IS ALLERGIC TO:
1. PENICILLIN.
2. PENTOTHAL.
3. MORPHINE.
4. THE PATIENT ALSO IS ALLERGIC TO DIFFERENT TYPES OF TAPE.

SOCIAL HISTORY:

The patient is a smoker. Denies any alcohol consumption. Denies any history of IV drug abuse.

PHYSICAL EXAMINATION:

VITAL SIGNS: The patient's examination shows she is 5 feet 3 inches, 158 pounds, her blood pressure is 149/94, and she is afebrile. GENERAL: She is able to stand and ambulate. She has no weakness in the upper and lower extremities. HEENT: The patient has no adenopathy, no thyroid enlargement. The patient had normal pupils. Tongue was midline. Cranial nerves were intact. LUNGS: Clear to auscultation anterior and posterior. CARDIOVASCULAR EXAMINATION: Regular without any murmur. ABDOMEN: Obese. There was no guarding or rigidity. Had normoactive bowel sounds. MUSCULOSKELETAL: She was not tender to palpation of the cervical, thoracic, or lumbar spine. The patient had normal reflexes in upper and lower extremities and symmetrically so. Her strength is 5/5 in upper and lower extremities. SKIN: Dry and warm. NEUROLOGIC: There was no allodynia. She had normal sensation. Her pulses were normal. There was no peripheral edema. The patient had pain with straight leg raising in the back, but no radicular component pain. She had good range of motion of the hip and the knee. Her gait was normal without any ataxia.

I did review the MRI of the lumbar spine, which was done here at UPMC Mercy Hospital. It was available on the Stentor System.

The patient had a disk bulge at L4-L5 with spondylolisthesis at that level or an anterolisthesis at that level and some neuroforaminal stenosis. She had scar at L5-S1.

After discussing with the patient thoroughly the risks and benefits, today I did perform a lumbar epidural steroid injection, which was well tolerated.

PROCEDURE NOTE:

With informed consent, the patient was placed in the prone position. ChloraPrep was applied in a wide and thorough prep. This was allowed to completely dry. Then, Betadine was applied. Sterile draping was utilized. Skin infiltration was performed with 5 mL of 1% lidocaine. Then, under fluoroscopic guidance, an 18-gauge Tuohy needle was advanced into the interlaminar epidural plane. No heme or CSF was aspirated. Methylprednisolone was then drawn up sterilely and instilled 80 mg in a volume of 2 mL preservative-free saline. Needle tract was cleared. The patient tolerated

*U*P*M*C* FONTANA,TRISH Acct#:0334426881334
this well. The patient was given prescriptions for tramadol and Neurontin, and was given a return appointment.

Authenticated electronically at end of document

Dictator: Gregg G. Weidner, M.D.

GGW/sn

D: 01/12/2012 07:58:00
T: 01/12/2012 11:51:33
R: 01/12/2012 11:51:33/sn
43435127/3833218/39745049

CC:

Authenticated by GREGG G WEIDNER, MD On 01/18/2012 07:10:08 AM

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH A DOB: 06/02/1967

MRN: 980404528 Gender: F Location: URAD (MCY)

Exam Desc: MR SPINE LUMBAR WITH AND WITHOUT CONTRAST

Accession Date: 11/11/2011 16:51
Dictated on : 11/12/2011 09:35

Attending MD: JORY D RICHMAN

Requesting MD: JORY D RICHMAN

Accession #: 65720569 Visit Number: 0334426881314

Attending Interpreter: KHURSHED J DASTUR
Assisting Interpreter:

*** FINAL REPORT ***

Reason for the Exam: MR1/DX: BACK PAIN

CLINICAL HISTORY:
Back pain. Status post surgery 06/30/11.

COMPARISON:
MRI lumbar spine 06/22/2011.

TECHNIQUE:
Multiplanar, multipulse images are obtained emphasizing T1 and T2-weighted imaging. Sagittal STIR images are also obtained. Examination is performed with and without the IV infusion of 14cc MultiHance.

FINDINGS:
There is again noted grade 1 degenerative anterolisthesis L4 on L5 with narrowing of the disc space. L5-S1 disc space is also slightly narrowed. Scout images reveal 5 lumbar vertebral bodies. The cerebellar tonsils are low-lying and could be evaluated further by MRI of brain if indicated.

At L5-S1 level: A right-sided laminectomy defect is noted. Enhancingpost laminectomy scarring is noted extending into the right lateral aspect of the spinal canal and into the anterior epidural space. The scar tissue surrounds the right S1 root. The thecal sac is not displaced.

At L4-5 level: There is diffuse bulging of disc annulus and some unroofing of the disc. In addition,facetal degenerative changes are noted. There is narrowing of lateral recesses and central dimensions of the spinal canal. There is some inferior foraminal narrowing noted bilaterally. Exiting root shows no compression.

At L3-4 level: The disc contour is unremarkable and canal dimensions are normal.

At the L2-3 level: The disc contour is unremarkable and canal dimensions are normal.

<<< PAGE 1 >>>

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH A DOB: 06/02/1967

MRN: 980404528 Gender: F Location: URAD (MCY)

Exam Desc: MR SPINE LUMBAR WITH AND WITHOUT CONTRAST

Accession Date: 11/11/2011 16:51
Dictated on : 11/12/2011 09:35

Attending MD: JORY D RICHMAN

Requesting MD: JORY D RICHMAN

Accession #: 65720569 Visit Number: 0334426881314

Attending Interpreter: KHURSHED J DASTUR
Assisting Interpreter:

At L1-2 level: There is some bulging of disc annulus. This is slightly eccentric to the left. Canal dimensions are normal.

The conus terminates at T12-L1 level and shows no compression. Signal of the conus appears normal.

IMPRESSION:
1. Right laminectomy at L5-S1 level. There is enhancing post laminectomy scarring extending into the right lateral aspect of the spinal canal and into the anterior epidural space. There is no definite nonenhancing tissue to suggest definite residual or recurrent disc protrusion. Scar tissue surrounds the right S1 root.
2. At L4-5 level, there is degenerative anterolisthesis of L4 on L5 with bulging and unroofing of the disc. There is central spinal stenosis at this level.
3. Some bulging of disc annulus noted at L1-2 level slightly eccentric to the left.

END OF IMPRESSION:
RELEVANT CLINICAL INFORMATION: MR1/DX: BACK PAIN
Dictated by: KHURSHED J DASTUR
Signed by: KHURSHED J DASTUR
Signed on: 11/12/2011 at 09:35 AM

<<< PAGE 2 >>>

UPMC

INVOICE

Health Information Management
Release of Information Department
Melwood Building – Lower Level
200 Lothrop Street
Pittsburgh, PA 15213

Date May 18, 2013
Request # 246266

BILL TO:
Bureau of Disability
S67 Greensburg/PA-DDS P O Box 8751
London KY 40742

Patient Name	Medical Record/Soc Security #	UPMC Facility
FONTANA, TRISH A	980404528	Mercy (MCY)

Total Pages Released	9
Balance Due	$26.12

Dear Requestor:
This letter is to inform you that the Health Information Management, Release of Information Department for UPMC Mercy Hospital has received your request for release of medical record information on the above referenced patient(s). Enclosed are the medical records that you have requested.

Payments
Please make check or money order payable to UPMC Mercy Hospital and be sure to include this invoice along with the payment. All payments are to be sent to the UPMC address at the top of this letter. For your records, our tax id number is 25-0965429. If you would like to make a payment via credit card, log onto the following website and choose "Medical Record" as the Type of Bill. Information from your invoice will be needed. https://npaybill.upmc.com

Films and Photographs
Please note that a request for a complete medical record will not include photographic or radiographic images. Photographs will need to be specifically requested on the authorization. Radiology images will need to be requested from the appropriate radiology department located in the hospital at which the patient was seen.

Questions/Canceling Requests
If records are no longer needed or you wish to cancel this request for any reason, please notify the Release of Information Department so that the balance can be removed from your name. All cancellations and any questions related to this invoice can be directed to the Release of Information Department at 412-802-0100, Monday – Friday, 8:00am – 5:00pm.

DISCLOSURE STATEMENTS:

_____*This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.*

_____*This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains. This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.*

The paper copy of an electronic record can vary in format and content, depending on how or when the record was printed. If there are questions as to the format or content of the electronic chart, please contact us at the number above.

The paper copy of the electronic anesthesia record may contain truncated data. If the banner bar of the anesthesia record contains the statement "Actions – Refer to the electronic record for complete data", please contact us at the number above if the complete anesthesia record is needed.

EXHIBIT NO. 7F
PAGE: 1 OF 6

Return MAIL or FAX Cover Sheet

IMPORTANT: THIS SHEET MUST BE ON TOP OF YOUR RESPONSE. If you are required to return your own cover sheet, please place it under this one.

BILL TO SHIP TO

GREGG WEIDNER MD
UPMC PAIN MEDICINE AT MERCY
1350 LOCUST ST SU 411
PGH PA 15219

PATIENT

Re: TRISH A FONTANA
XXX-XX-3849

SSA
S67 Greensburg/PA-DDS
PO Box 8751
London, KY 40742-9863

If responding by mail, put this sheet on top of your response. Use the enclosed return envelope and ensure that the mailing address appears in the window.

If responding by FAX, complete the FAX Information section and send to the FAX Number identified below. Put this sheet on top of your FAX transmission.

FAX Information

Date: _____ Time: _____ Number of Pages, including this cover sheet: _____

To: Bureau of Disability Determination

Attn: M. Servello Phone Number: 1-800-442-8018

FAX Number: 1-800-358-9954

The information contained in this facsimile is intended only for the individual named above and may contain confidential or privileged information. If you are not the intended recipient, any dissemination, distribution or copying of this communication is prohibited. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for the return of all documents transmitted.

232919472 T5
022662032 3
BBZZC1
MER - DMAF

RQID:022662032 38BZZC1 SITE:S67 DR:S
SSN:197563849 DOCTYPE:0001 RF:D CS:3F77

60049524 4/13

HealthPort
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
(770) 754 - 6000

Date
5/13/2013

HealthPortConnect

Ship to:

M SERVELLO
DISABILITY DETERMINATIONS
PO BOX 2500
GREENSBURG, PA 15605-2500

Requested By: DISABILITY DETERMINATIONS
Patient Name: FONTANA TRISH A
SSN: 197563849
TDN NUMBER: 0226620323

Records from:

UPMC179-PAIN MEDICINE AT MERCY
1350 LOCUST ST. STE 411
MERCY PROFESSIONAL BLDG.
PITTSBURGH, PA 15219

Please Note: Your medical record request has been delivered electronically to your HealthPort Connect account.

0127368333

HealthPort
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
(770) 754 - 6000

HealthPort processes thousands of requests for health information at over 6,500 health care facilities nationwide. If you would like to learn more about HealthPort, or how our suite of services can benefit your facility, please visit our website at: www.HealthPort.com or email us at: marketing@HealthPort.com

Your Name _____

Title _____

Facility Name _____

Phone Number (____) _____

Address _____

_____

City _____ State ____ Zip _____

# of Physicians _____ Specialty _____

# of Beds _____ # of Admits _____

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF DISABILITY DETERMINATION
POST OFFICE BOX 2500
GREENSBURG, PENNSYLVANIA 15605-2500
FROM GREENSBURG CALL: 724-836-5100
ALL OTHER AREAS CALL: 800-442-8018
TTY USERS CALL: 800-654-5984
FAX: Use enclosed FAX Cover Sheet

BDD SERVICE INVOICE

TDN: 0226620323

AUTHORIZED BY: M. Servello/MQS
OBLIGATED DATE: 04/23/13

PROVIDER TO BE PAID:
HEALTHPORT TECHNOLOGIES LLC
PO BOX 409822
ATLANTA GA 30384-9822

PHONE: (412) 232-4040

CLAIMANT NAME, ADDRESS AND SSN:
TRISH A FONTANA
3130 GLENDALE AVENUE
PITTSBURGH PA 15227
XXX-XX-3849

TREATMENT LOCATION:
UPMC PAIN MEDICINE AT MERCY
1350 LOCUST ST SU 411
PGH PA 15219

(COMPLETE IF BLANK)
Federal ID Number OR Provider Social Security Number: **582659941**

☐ "X" this box if changes were made to preprinted Name/Address or Tax ID Number.

CODE AND TYPE OF SERVICE:		FEE
045 Medical Evidence from Physicians/Psychologists		
Original Abstract	-OR-	$ _____
Photocopied Records		$ _____
055 Medical Source Statement		$ _____
047 Hospital Records - Hospital Use Only		$ _____

Should an additional examination or test be needed to complete this patient's disability claim, are you willing to perform it? Yes____ No____

TOTAL: $ _____

_____
Provider Signature

We certify that the above item(s) or kind(s) of service(s) were actually rendered and that the above prices and terminology are in accordance with the BDD's Authorization for Services. Payment cannot be made for unauthorized services. Neither the claimant nor his/her health insurer may be charged any fee for these services. In submitting this invoice for payment, the provider certifies that the fees charged are not in excess of those charged private patients or Federal or other agencies in the Commonwealth for the same or similar types of services.

PAYMENT WILL NOT BE AUTHORIZED FOR RECORDS RECEIVED AFTER 90 DAYS FROM THE DATE OF THIS LETTER.

**********-OFFICIAL USE ONLY-**********

____Medical Records- Photocopy -OR- ____Medical Evidence- Original Abstract

____Medical Source Statement

232919472 T5 BBZZC1

0226620323

208PH 5/12 DMAF

60049524- 5/13

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF DISABILITY DETERMINATION
POST OFFICE BOX 2500
GREENSBURG, PENNSYLVANIA 15605-2500
FROM GREENSBURG AREA: 724-836-6100
ALL OTHER AREAS CALL: 800-442-3018
TTY USERS CALL
FAX: Use enclosed FAX Cover Sheet

02266203 23

5/7/13, OM, Zou-T
5/7/13

GREGG WEIDNER MD
UPMC PAIN MEDICINE AT MERCY
1350 LOCUST ST SU 411
PGH PA 15219

EXT. 3745
DATE: 04/23/13
SSN: ~~XXX-XX-3849~~
NAME: TRISH A FONTANA
ADDRESS: 3130 GLENDALE AVENUE
PITTSBURGH PA 15227
BIRTH DATE: 06/02/67

Dear Doctor:

This patient's claim for disability benefits under the Social Security Act has been referred to this agency. In order to evaluate the claim (establish onset, severity and duration of any impairment), we need a **copy of your existing records** between **2011** and **present**. Also, please complete the Medical Source Statement of Claimant's Ability to Perform Work-Related Activities and/or any additional questions, if enclosed.

If you charge a fee for preparing this information, please complete the BDD Service invoice, if enclosed. We can reimburse you up to:

- $26.70 for photocopied records
- $10.00 additional for the Medical Source Statement if one is enclosed
- $30.00 for an original abstract and Medical Source Statement

We cannot prepay or pay any State or Federal facilities. If you are such a facility, you will not find an invoice with this request.

You can fax to the number on the enclosed fax/mail cover sheet at any time or use our 24 hour telerecording service at 800-492-2514 to dictate your report. A copy of any medical information you provide via telephone will be sent to you for verification and signature.

Please try to complete this request within 10 days.

Sincerely,

M. Servello/MQS
Disability Claims Adjudicator

Michael Niemiec, D.O.
Reviewing Physician

BBZZC1
ENCLOSURE. Disclosure Authorization, Return Envelope, BDD Service Invoice
A 10/24/12 DMAF

60049524 - 13/13

Form Approved
OMB No. 0960-0566

WHOSE Records to be Disclosed

NAME *(First, Middle, Last, Suffix)*
Trish Ann Fontana

SSN **197-56-3849** | Birthday *(mm/dd/yy)* **06/02/67**

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records; also education records and other information related to my ability to perform tasks.*** **This includes specific permission to release:**

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) ***including,*** **and not limited to:**

- Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
- Drug abuse, alcoholism, or other substance abuse
- Sickle cell anemia
- Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
- Gene-related impairments (including genetic test results)

2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

UPMC PAIN MEDICINE AT MERCY
2011 TO PRESENT

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits,** including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.
☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including **electronic** copy) of this form for the disclosure of the information described above
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY
INDIVIDUAL authorizing disclosure

SIGN ▶ *Electronically Signed By:*
Trish Ann Fontana

IF not signed by subject of disclosure, specify basis for authority to sign
☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
04/18/13	**3130 GLENDALE AVE**		
Phone Number (with area code)	City	State	ZIP
412-882-0719	**PITTSBURGH**	**PA**	**15227**

WITNESS *I know the person signing this form or am satisfied of this person's identity.*

Attested by SSA or Designated State Agency Employee:
SIGN ▶ **O. Moore**

IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN ▶

Phone Number (or **Address**)
866-717-1525 PITTSBURGH PA 15228-2706

Phone Number (or **Address**)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"), 34 CFR parts 99 and 300; and State law.

HealthPort.

Patient's Name: TRISH FONTANA DOB: 06/02/1967

Dear Requester:

HealthPort is under agreement with the medical facility to release all authorized copies of medical records. We regret that we cannot respond to your request for records at this time due to the following:

☒ **There are No Dates of Treatment** for the records you have requested.

☐ **A Death Certificate or "Letter of Administration/Testament"** must accompany the request for records for a deceased individual. Requests for records regarding deceased or incapacitated individuals must be accompanied by documentation which supports that the individual requesting, and/or authorizing the release of this information, is legally capable of doing so. Please re-request and provide the necessary supporting documentation (i.e. Court documents naming the signer as the executor of the estate, official paperwork naming the signer as the individual's healthcare power of attorney, or death certificate which names the signer as the next-of-kin).

☐ **Inadequate Authorization** The SSN on the authorization does not match our system. Please correct and resubmit your request.

☐ **Inadequate Authorization** A proper authorization to release records was not included with your request. Please have the patient or his/her healthcare power of attorney/legal guardian complete an authorization form and return it to the medical facility, along with your original request. Once received, the information will be sent to the address listed on the authorization.

☐ **Unable to identify patient** Additional information is needed to indentify the correct patient. Please provide a date of birth or social security number, and or any other names used by the patient.

☐ **HIPAA-compliant authorization** Patient authorization must contain statements of notification to the patient. One or more of the following statements is missing from your authorization.

- ☐ Individual's right to revoke authorization
- ☐ Description of how to revoke it
- ☐ Ability or inability to condition their treatment, payment, enrollment or eligibility for benefits
- ☐ Potential for disclosed information to be re-disclosed by recipient

☐ **HIPAA-compliant request for medical records** Request for medical records must include all the information below. One or more core elements are missing from your request.

- ☐ Name of patient
- ☐ Description of the information to be disclosed
- ☐ Name of person/company authorized to make use of disclosure
- ☐ Description of each purpose for the disclosure
- ☐ Expiration date or event for which the request will expire

☐ **Special Authorization Required** The chart contains sensitive information. Release must specify that permission is given to disclose such information.

☐ **The Patient Authorization has expired**

☐ **The Patient is Not a Minor** Patient must sign for himself/herself.

☐ **Other:**

This sheet MUST be on top of your response. This sheet must be on top of your response.

EXHIBIT NO. 8F
PAGE: 1 OF 11

Return MAIL or FAX Cover Sheet

IMPORTANT: THIS SHEET MUST BE ON TOP OF YOUR RESPONSE. If you are required to return your own cover sheet, please place it under this one.

JORY RICHMAN MD
UNIVERSITY OF PGH PHYSICIANS
DEPT OF ORTHOPAEDIC SURGERY
UPMC MERCY PROFESSIONAL BLDG
1350 LOCUST ST SU 220
PGH PA 15219

Re: TRISH A FONTANA
XXX-XX-3849

SSA
S67 Greensburg/PA-DDS
PO Box 8751
London, KY 40742-9863

If responding by mail, put this sheet on top of your response. Use the enclosed return envelope and ensure that the mailing address appears in the window.

If responding by FAX, complete the FAX Information section and send to the FAX Number identified below. Put this sheet on top of your FAX transmission.

FAX Information

Date: _____ Time: _____ Number of Pages, including this cover sheet: _____

To: Bureau of Disability Determination

Attn: M. Servello Phone Number: 1-800-442-8018

FAX Number: 1-800-358-9954

The information contained in this facsimile is intended only for the individual named above and may contain confidential or privileged information. If you are not the intended recipient, any dissemination, distribution or copying of this communication is prohibited. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for the return of all documents transmitted.

232919472 R7
022662O216
BBZZC1
MER - DMAF

RQID:022662O216BBZZC1 SITE:S67 DR:S
SSN:197563849 DOCTYPE:0001 RF:D CS:3d9a

60049523- 4/13

HealthPort
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
(770) 754 - 6000

HealthPort INVOICE

Invoice #: 0128271811
Date: 5/29/2013
Customer #: 1132929

Ship to:	Bill to:	Records from:
M SERVELLO DISABILITY DETERMINATIONS PO BOX 2500 GREENSBURG, PA 15605-2500	M SERVELLO DISABILITY DETERMINATIONS PO BOX 2500 GREENSBURG, PA 15605-2500	UPMC152-MERCY ORTHOPAEDIC 1350 LOCUST ST. STE 220 MERCY PROFESSIONAL BLDG. PITTSBURGH, PA 15219

Requested By: DDS
Patient Name: FONTANA TRISH A

SSN: 197563849
TDN NUMBER: 0226620216

Description	Quantity	Unit Price	Amount
Basic Fee			26.70
Retrieval Fee			0.00
Per Page Copy (Paper) 1	6	0.00	0.00
Subtotal			26.70
Sales Tax			0.00
Invoice Total			26.70
Balance Due			26.70

Pay your invoice online at www.HealthPortPay.com

Terms: Net 30 days

Please remit this amount : $ 26.70 (USD)

HealthPort
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
(770) 754 - 6000

Invoice #: **0128271811**

Check # _____

Payment Amount $_____

Please return stub with payment.

Please include invoice number on check.
To pay invoice online, please go to www.HealthPortPay.com or call (770) 754 6000.
Email questions to Collections@healthport.com.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF DISABILITY DETERMINATION
POST OFFICE BOX 2500
GREENSBURG, PENNSYLVANIA 15605-2500
FROM GREENSBURG CALL: 724-836-5100
ALL OTHER AREAS CALL: 800-442-6018
TTY USERS CALL:
FAX: *Use enclosed FAX Cover Sheet*

BDD SERVICE INVOICE

TDN: 0226620216

AUTHORIZED BY: M. Servello/MQS
OBLIGATED DATE: 04/23/13

PROVIDER TO BE PAID:
HEALTHPORT TECHNOLOGIES LLC
PO BOX 409822
ATLANTA GA 30384-9822

PHONE: (412) 232-5800

CLAIMANT NAME, ADDRESS AND SSN:
TRISH A FONTANA
3130 GLENDALE AVENUE
PITTSBURGH PA 15227
XXX-XX-3849

TREATMENT LOCATION:
UNIVERSITY OF PGH PHYSICIANS
DEPT OF ORTHOPAEDIC SURGERY
UPMC MERCY PROFESSIONAL BLDG
1350 LOCUST ST SU 220
PGH PA 15219

(COMPLETE IF BLANK)
Federal ID Number OR Provider Social Security Number: **582659941**

☐ "X" this box if changes were made to preprinted Name/Address or Tax ID Number.

CODE AND TYPE OF SERVICE:		**FEE**
045 Medical Evidence from Physicians/Psychologists		
Original Abstract	-OR-	$ _____
Photocopied Records		$ _____
055 Medical Source Statement		$ _____
047 Hospital Records - Hospital Use Only		$ _____

Should an additional examination or test be needed to complete this patient's disability claim, are you willing to perform it? Yes____ No____

TOTAL: $ _____

_____
Provider Signature

We certify that the above item(s) or kind(s) of service(s) were actually rendered and that the above prices and terminology are in accordance with the BDD's Authorization for Services. Payment cannot be made for unauthorized services. Neither the claimant nor his/her health insurer may be charged any fee for these services. In submitting this invoice for payment, the provider certifies that the fees charged are not in excess of those charged private patients or Federal or other agencies in the Commonwealth for the same or similar types of services.

PAYMENT WILL NOT BE AUTHORIZED FOR RECORDS RECEIVED AFTER 90 DAYS FROM THE DATE OF THIS LETTER.

**********-OFFICIAL USE ONLY-**********

____Medical Records- Photocopy -OR- ____Medical Evidence- Original Abstract

____Medical Source Statement

232919472 R7 BBZZC1

0226620216

208PH 5/12 DMAF

60049523- 5/13

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF DISABILITY DETERMINATION
POST OFFICE BOX 2500
GREENSBURG, PENNSYLVANIA 15605-2500
FROM GREENSBURG AREA: 724-836-5100
ALL OTHER AREAS CALL: 800-442-6018
TTY USERS CALL: 800-442-6018
FAX: *Use enclosed FAX Cover Sheet*

0226620216

4/30/13, CA, 2011-?

JORY RICHMAN MD
UNIVERSITY OF PGH PHYSICIANS
DEPT OF ORTHOPAEDIC SURGERY
UPMC MERCY PROFESSIONAL BLDG
1350 LOCUST ST SU 220
PGH PA 15219

EXT. 3745
DATE: 04/23/13
SSN: XXX-XX-3849
NAME: TRISH A FONTANA

ADDRESS: 3130 GLENDALE AVENUE
PITTSBURGH PA 15227
BIRTH DATE: 06/02/67

Dear Doctor:

This patient's claim for disability benefits under the Social Security Act has been referred to this agency. In order to evaluate the claim (establish onset, severity and duration of any impairment), we need a **copy of your existing records** between **2011** and **present**. Also, please complete the Medical Source Statement of Claimant's ~~Ability to Perform~~ Work-Related Activities and/or any additional questions, if enclosed.

If you charge a fee for preparing this information, please complete the BDD Service invoice, if enclosed. We can reimburse you up to:

- $26.70 for photocopied records
- $10.00 additional for the Medical Source Statement if one is enclosed
- $30.00 for an original abstract and Medical Source Statement

We cannot prepay or pay any State or Federal facilities. If you are such a facility, you will not find an invoice with this request.

You can fax to the number on the enclosed fax/mail cover sheet at any time or use our 24 hour telerecording service at 800-492-2514 to dictate your report. A copy of any medical information you provide via telephone will be sent to you for verification and signature.

Please try to complete this request within 10 days.

Sincerely,

RECEIVED
APR 29 2013
By

M. Servello/MQS
Disability Claims Adjudicator

Michael Niemiec, D.O.
Reviewing Physician

BBZZC1
ENCLOSURE: Disclosure Authorization, Return Envelope, BDD Service Invoice
A 10/24/12 DMAF

60049523- 13/13

Form Approved
OMB No. 0960-0623

WHOSE Records to be Disclosed

NAME *(First, Middle, Last, Suffix)*
Trish Ann Fontana

SSN **197-56-3849** | Birthday *(mm/dd/yy)* **06/02/67**

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I **voluntarily authorize and request disclosure** (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records; also education records and other information related to my ability to perform tasks.*** **This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including,*** **and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

UNIVERSITY OF PGH PHYSICIANS
2011 TO PRESENT

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits,** including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.
☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
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- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY
INDIVIDUAL authorizing disclosure

SIGN ▶ *Electronically Signed By:*
Trish Ann Fontana

IF not signed by subject of disclosure, specify basis for authority to sign
☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
04/18/13	**3130 GLENDALE AVE**		
Phone Number (with area code)	City	State	ZIP
412-882-0719	**PITTSBURGH**	**PA**	**15227**

WITNESS *I know the person signing this form or am satisfied of this person's identity.*

Attested by SSA or Designated State Agency Employee:
SIGN ▶ **O. Moore**

IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN ▶

Phone Number (or Address)	Phone Number (or Address)
888-717-1525 PITTSBURGH PA 15228-2706	

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300, and State law.

60049523 - 3/13

UPMC PSD-ORTHOSURG MERCY

OFFICE NOTE

FONTANA, TRISH A
DOB: 06/02/1967
DOV: 04/24/2013

HISTORY OF PRESENT ILLNESS: Trish returns today complaining of a pain in her cervical region for the past several weeks. She does not recall any antecedent injury or trauma. She describes a neck pain that radiates into the right posterior shoulder area. She is not having any radicular pain, however. She was recently seen in the Emergency Department and an MRI was obtained to be discussed below.

Her physical examination is benign. She has no motor deficits in her upper extremities. She has a full range of motion of her cervical spine. Spurling's test is negative. She has a full painless range of motion of both shoulders with no impingement.

MRI imaging of her cervical spine reveals a disk osteophyte complex at C4-C5 that is causing mild to moderate foraminal narrowing. She does not have any spinal cord reformation or compression.

Trish has a bulging disk and osteophyte at C4-C5 that does not require surgical treatment. She is neurologically intact. She will begin a course of physical therapy and follow up with me on an as-needed basis.

Jory D Richman, M.D.

D: 04/24/2013 04:22PM, JDR **T:** 04/25/2013 07:15AM, gn **R:**
Confirmation # M510635/ Document ID: 2068548

FONTANA, TRISH A
DOB: 06/02/1987
DOV: 04/23/2012

OFFICE NOTE

SUBJECTIVE: Trish continues to complain of significant lower back pain with radiation into both lower extremities, although not purely in a dermatomal pattern. She is now nearly 1 year out from a microdiskectomy at L5-S1.

OBJECTIVE: Her physical examination is benign. She has no motor or sensory deficits in her lower extremities. Straight-leg raising is negative. She has a full painless range of motion of both hips.

Her repeat MRI scan revealed some borderline spinal stenosis and early degenerative spondylolisthesis at L4-5.

ASSESSMENT AND PLAN: Given the severity of her symptoms, I have recommended CT myelography of her lumbar spine, and I will see her back once that test is complete.

Jory D. Richman, MD

D: 04/23/2012 10:37 AM (EST) T: 04/23/2012 10:52 AM (EST)
DJN: 92105361
SJN: 55747619
179675

FONTANA, TRISH A
DOB: 06/02/1967
DOV: 11/21/2011

OFFICE NOTE

SUBJECTIVE: Trish returns following an MRI of her lumbar spine.

OBJECTIVE: The disk herniation which she had at L5-S1 is no longer present, and there is no evidence of residual or recurrent disk herniation at that level. She does have a mild degree of spinal stenosis, as well as a grade 1 degenerative spondylolisthesis at L4-5 which is unchanged from her previous preoperative MRI scan. She complains of contralateral left leg pain with lower back symptoms as well.

ASSESSMENT AND PLAN: I have recommended that she try a course of physical therapy to see if this helps alleviate some of her chronic back and leg pain. I have also recommended that she try epidural steroid injections. If there is no improvement with these modalities, she will require a CT myelogram of her lumbar spine. I will see her back if her pain does not improve.

Jory D. Richman, MD

D: 11/21/2011 10:12 AM (EST) T: 11/21/2011 10:19 AM (EST)
DJN: 91915150
SJN: 51318027
179675

FONTANA, TRISH A
DOB: 06/02/1967
DOV: 11/09/2011

OFFICE NOTE

SUBJECTIVE: Trish has had a severe flareup of lower back pain at this time that radiates into her left lower extremity. Previously her symptoms were on the right side. She has had this pain for the past few days and has been steadily becoming more and more severe. She is having difficulty walking due to her discomfort.

OBJECTIVE: On physical examination, she has a considerable amount of back spasm. She has no motor deficits in her lower extremities. Straight leg raising reproduces back pain, but no leg pain.

ASSESSMENT/PLAN: Given the severity of her pain, I have recommended MRI imaging with contrast of her lumbar spine. She was also placed on a Medrol Dosepak and given a refill of Vicodin. I will see her back once her MRI scan is complete.

Jory D. Richman, MD

D: 11/09/2011 02:42 PM (EST) T: 11/10/2011 01:07 PM (EST)
DJN: 91899975
SJN: 50984370
792175

FONTANA, TRISH ANN
DOB: 06/02/1967
DOV: 09/19/2011

OFFICE NOTE

SUBJECTIVE: Trish Ann reports a recurrence in low back pain, 3 months status post a microdiskectomy at L5-S1. She has some radiation of pain into both lower extremities, although it is not nearly as severe as it had been when she first ruptured her disk.

OBJECTIVE: She has no motor deficits in her lower extremities. Straight leg raising is mildly positive on the right side. Straight leg raising on the left reproduces back pain but no leg pain.

ASSESSMENT/PLAN: Trish Ann may have a recurrent herniation, although this could represent mechanical back pain only. I have recommended that she try a Medrol Dosepak as well as occasional use of Percocet. She will also begin physical therapy for her lumbar spine. If there is no further improvement after 3 more weeks of conservative management, she will require an MRI with contrast of her lumbar spine. I will see her back in 3 weeks.

Jory D. Richman, MD

D: 09/19/2011 08:38 AM (EST) T: 09/19/2011 09:41 AM (EST)
DJN: 91826685
SJN: 49424964
180246

cc: Dushan Majkic, MD
Brentwood Medical Group
3720 Brownsville Road
Pittsburgh, PA 15227

FONTANA, TRISH ANN
DOB: 06/02/1967
DOV: 06/27/2011

OFFICE NOTE

SUBJECTIVE: Trish Fontana is a young woman referred from the emergency department for evaluation of spontaneous onset of lower back pain in the right side with severe sciatica in the right lower extremity that began 3 weeks ago. Her back pain has improved; however, her sciatica has not improved to any significant extent and follows an S1 dermatome.

PAST MEDICAL HISTORY: Unremarkable. She has no medical illnesses.

PHYSICAL EXAMINATION: She is a pleasant, normally developed, 44-year-old woman accompanied by her husband. She is standing as sitting causes a great deal of discomfort. She has a markedly positive straight-leg raising sign on the right side with an absent Achilles reflex, and diminished strength in her EHL on the right side as well.

DIAGNOSTIC TEST RESULTS: Review of an MRI scan reveals a large, extruded L5-S1 disk herniation on the right side consistent with her clinical symptoms.

ASSESSMENT AND PLAN: She has a large disk herniation, and we discussed the option of a microdiskectomy. The surgical risks were reviewed with her and her husband, including the risk of nerve injury, vascular injury, infection, CSF leak, and recurrence. All questions were answered, and surgery will be performed later this week.

Jory D. Richman, MD

D: 06/27/2011 09:51 AM (EST) T: 06/27/2011 10:04 AM (EST)
DJN: 91711535
SJN: 46958279
180246

This sheet MUST be on TOP *This sheet MUST be on TOP*

EXHIBIT NO. 9F
PAGE: 1 OF 6

Return MAIL or FAX Cover Sheet

IMPORTANT: THIS SHEET MUST BE ON TOP OF YOUR RESPONSE. If you are required to return your own cover sheet, please place it under this one.

GREGG G WEINER MD
UPMC MERCY
PAIN MANAGEMENT CENTER
1350 LOCUST ST BLDG C SU 411
PGH PA 15219

PT dob 06/02/1967

Re: TRISH A FONTANA
XXX-XX-3849

Bill/mail to:

SSA
S67 Greensburg/PA-DDS
PO Box 8751
London, KY 40742-9863

If responding by mail, put this sheet on top of your response. Use the enclosed return envelope and ensure that the mailing address appears in the window.

If responding by FAX, complete the FAX Information section and send to the FAX Number identified below. Put this sheet on top of your FAX transmission.

FAX Information

Date: _____ Time: _____ Number of Pages, including this cover sheet: _____

To: Bureau of Disability Determination

Attn: M. Servello Phone Number: 1-800-442-8018

FAX Number: 1-800-358-9954

The information contained in this facsimile is intended only for the individual named above and may contain confidential or privileged information. If you are not the intended recipient, any dissemination, distribution or copying of this communication is prohibited. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for the return of all documents transmitted.

250965429 02
0227743712
BBZZC1
MER - DMAF

RQID:0227743712BBZZC1 SITE:S67 DR:S
SSN:197563849 DOCTYPE:0001 RF:D CS:71f8

HealthPort
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
(770) 754 - 6000

Date
5/25/2013

HealthPortConnect

Ship to:

M SERVELLO
DISABILITY DETERMINATIONS
PO BOX 2500
GREENSBURG, PA 15605-2500

Requested By: DISABILITY DETERMINATION
Patient Name: FONTANA TRISH A
SSN: 197563849
TDN NUMBER: 0227743712

Records from:

UPMC179-PAIN MEDICINE AT MERCY
1350 LOCUST ST. STE 411
MERCY PROFESSIONAL BLDG.
PITTSBURGH, PA 15219

Please Note: Your medical record request has been delivered electronically to your HealthPort Connect account.

0128101660

HealthPort
P.O. Box 409822
Atlanta, GA 30384-9822
Fed Tax ID 58 - 2659941
(770) 754 - 6000

HealthPort processes thousands of requests for health information at over 6,500 health care facilities nationwide. If you would like to learn more about HealthPort, or how our suite of services can benefit your facility, please visit our website at: www.HealthPort.com or email us at: marketing@HealthPort.com

Your Name _____

Title _____

Facility Name _____

Phone Number (____) _____

Address _____

_____

City _____ State ____ Zip _____

# of Physicians _____ Specialty _____

# of Beds _____ # of Admits _____

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

BUREAU OF DISABILITY DETERMINATION
POST OFFICE BOX 2500
GREENSBURG, PENNSYLVANIA 15605-2500

FROM GREENSBURG CALL: 724-838-7100
ALL OTHER AREAS CALL: 800-440-3520
TTY USERS CALL: 711
FAX: *Use enclosed FAX Cover Sheet*

BDD SERVICE INVOICE

TDN: 0227743712

AUTHORIZED BY: M. Servello/DJM
OBLIGATED DATE: 05/15/13

PROVIDER TO BE PAID:
HEALTHPORT TECHNOLOGIES LLC
PO BOX 409822
ATLANTA GA 30384-9822

PHONE: (412) 232-4040

CLAIMANT NAME, ADDRESS AND SSN:
TRISH A FONTANA
3130 GLENDALE AVENUE
PITTSBURGH PA 15227
XXX-XX-3849

TREATMENT LOCATION:
UPMC MERCY
PAIN MANAGEMENT CENTER
1350 LOCUST ST BLDG C SU 411
PGH PA 15219

(COMPLETE IF BLANK)
Federal ID Number OR Provider Social Security Number: **582659941**

☐ "X" this box if changes were made to preprinted Name/Address or Tax ID Number.

CODE AND TYPE OF SERVICE:		FEE
045 Medical Evidence from Physicians/Psychologists		
Original Abstract	-OR-	$ .....
Photocopied Records		$ .....
055 Medical Source Statement		$ .....
047 Hospital Records – Hospital Use Only		$ .....

Should an additional examination or test be needed to complete this patient's disability claim, are you willing to perform it? Yes____ No____

TOTAL: $ .....

....
Provider Signature

We certify that the above item(s) or kind(s) of service(s) were actually rendered and that the above prices and terminology are in accordance with the BDD's Authorization for Services. Payment cannot be made for unauthorized services. Neither the claimant nor his/her health insurer may be charged any fee for these services. In submitting this invoice for payment, the provider certifies that the fees charged are not in excess of those charged private patients or Federal or other agencies in the Commonwealth for the same or similar types of services.

PAYMENT WILL NOT BE AUTHORIZED FOR RECORDS RECEIVED AFTER 90 DAYS FROM THE DATE OF THIS LETTER.

**********-OFFICIAL USE ONLY-**********

____Medical Records- Photocopy -OR- ____Medical Evidence- Original Abstract

____Medical Source Statement

250965429 02 BBZ2C1

0227743712

208PH 5/12 DMAF

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

BUREAU OF DISABILITY DETERMINATION
POST OFFICE BOX 2500
GREENSBURG, PENNSYLVANIA 15605-2500

FROM GREENSBURG CALL: 724-838-5100
ALL OTHER AREAS CALL: 800-442-6009
TTY USERS CALL: 711
FAX: *Use enclosed FAX Cover Sheet*

0227743712

MOR

5/22/13, 6m 1/11-5/13
5/21/13

GREGG G WEIDNER MD
UPMC MERCY
PAIN MANAGEMENT CENTER
1350 LOCUST ST BLDG C SU 411
PGH PA 15219

EXT. 3745
DATE: 05/15/13
SSN: XXX-XX-3849
NAME: TRISH A FONTANA
ADDRESS: 3130 GLENDALE AVENUE
PITTSBURGH PA 15227
BIRTH DATE: 06/02/67

Dear Doctor:

This patient's claim for disability benefits under the Social Security Act has been referred to this agency. In order to evaluate the claim (establish onset, severity and duration of any impairment), we need a **copy of your existing records** between **01/2011** and **05/2013**. Also, please complete the Medical Source Statement of Claimant's Ability to Perform Work-Related Activities and/or any additional questions, if enclosed.

If you charge a fee for preparing this information, please complete the BDD Service invoice, if enclosed. We can reimburse you up to:

- $26.70 for photocopied records
- $10.00 additional for the Medical Source Statement if one is enclosed
- $30.00 for an original abstract and Medical Source Statement

We cannot prepay or pay any State or Federal facilities. If you are such a facility, you will not find an invoice with this request.

You can fax to the number on the enclosed fax/mail cover sheet at any time or use our 24 hour telerecording service at 800-492-2514 to dictate your report. A copy of any medical information you provide via telephone will be sent to you for verification and signature.

Please try to complete this request within 10 days.

Sincerely,

M. Servello/DJM
Disability Claims Adjudicator

Michael Niemiec, D.O.
Reviewing Physician

BBZZC1
ENCLOSURE: Disclosure Authorization, Return Envelope, BDD Service Invoice
A 10/24/12 DMAE

Form Approved
OMB No. 0960-0623

WHOSE Records to be Disclosed

NAME *(First, Middle, Last, Suffix)*
Trish Ann Fontana

SSN **197-56-3849** | Birthday *(mm/dd/yy)* **06/02/67**

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records; also education records and other information related to my ability to perform tasks.*** **This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** *including,* **and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

UPMC MERCY
01/2011 TO 05/2013

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits,** including looking at the combined effect of any impairments **that** by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.
☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY
INDIVIDUAL authorizing disclosure

SIGN ▶ *Electronically Signed By.*
Trish Ann Fontana

IF not signed by subject of disclosure, specify basis for authority to sign
☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
04/18/13	**3130 GLENDALE AVE**		
Phone Number (with area code)	City	State	ZIP
412-882-0719	**PITTSBURGH**	**PA**	**15227**

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

Attested by SSA or Designated State Agency Employee:
SIGN ▶ **O. Moore**

IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN ▶

Phone Number (or Address)
888-717-1525 PITTSBURGH PA 15228-2706

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"), 34 CFR parts 99 and 300; and State law.

HealthPort

Patient's Name: Trish Fontana DOB: 06/02/1967

Dear Requester:

HealthPort is under agreement with the medical facility to release all authorized copies of medical records. We regret that we cannot respond to your request for records at this time due to the following:

☒ **There are No Dates of Treatment** for the records you have requested.

☐ **A Death Certificate or "Letter of Administration/Testament"** must accompany the request for records for a deceased individual. Requests for records regarding deceased or incapacitated individuals must be accompanied by documentation which supports that the individual requesting, and/or authorizing the release of this information, is legally capable of doing so. Please re-request and provide the necessary supporting documentation (i.e. Court documents naming the signer as the executor of the estate, official paperwork naming the signer as the individual's healthcare power of attorney, or death certificate which names the signer as the next-of-kin).

☐ **Inadequate Authorization** The SSN on the authorization does not match our system. Please correct and resubmit your request.

☐ **Inadequate Authorization** A proper authorization to release records was not included with your request. Please have the patient or his/her healthcare power of attorney/legal guardian complete an authorization form and return it to the medical facility, along with your original request. Once received, the information will be sent to the address listed on the authorization.

☐ **Unable to identify patient** Additional information is needed to indentify the correct patient. Please provide a date of birth or social security number, and or any other names used by the patient.

☐ **HIPAA-compliant authorization** Patient authorization must contain statements of notification to the patient. One or more of the following statements is missing from your authorization.

- ☐ Individual's right to revoke authorization
- ☐ Description of how to revoke it
- ☐ Ability or inability to condition their treatment, payment, enrollment or eligibility for benefits
- ☐ Potential for disclosed information to be re-disclosed by recipient

☐ **HIPAA-compliant request for medical records** Request for medical records must include all the information below. One or more core elements are missing from your request.

- ☐ Name of patient
- ☐ Description of the information to be disclosed
- ☐ Name of person/company authorized to make use of disclosure
- ☐ Description of each purpose for the disclosure
- ☐ Expiration date or event for which the request will expire

☐ **Special Authorization Required** The chart contains sensitive information. Release must specify that permission is given to disclose such information.

☐ **The Patient Authorization has expired**

☐ **The Patient is Not a Minor** Patient must sign for himself/herself.

☐ **Other:** Authorization needs to be provider or facility specific

EXHIBIT NO. 10F
PAGE: 1 OF 2

This sheet MUST be on TOP *This sheet MUST be on TOP*

Return **MAIL** or **FAX** Cover Sheet

IMPORTANT: THIS SHEET MUST BE ON TOP OF YOUR RESPONSE. If you are required to return your own cover sheet, please place it under this one.

From: AMCE PHYSICIANS GROUP
PO BOX 460
HOOPER UT 84315

Re: TRISH A FONTANA
XXX-XX-3849

SSA
S67 Greensburg/PA-DDS
PO Box 8751
London, KY 40742-9863

If responding by mail, put this sheet on top of your response. Use the enclosed return envelope and ensure that the mailing address appears in the window.

If responding by FAX, complete the FAX Information section and send to the FAX Number identified below. Put this sheet on top of your FAX transmission.

FAX Information

Date: 6-12-13 Time: 12:00 Number of Pages, including this cover sheet: 2

To: Bureau of Disability Determination

Attn: M. Servello Phone Number: 1-800-442-8018

FAX Number: 1-800-358-9954

The information contained in this facsimile is intended only for the individual named above and may contain confidential or privileged information. If you are not the intended recipient, any dissemination, distribution or copying of this communication is prohibited. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange for the return of all documents transmitted.

263878273
02277440 95
BBZZC1

CE - DMAF

RQID:0227744095BBZZC101 SITE:S67 DR:S
SSN:197563849 DOCTYPE:0002 RF:D CS:ae55

352

EXHIBIT NO. 10F
PAGE: 2 OF 2

M. Servello
AMCE PHYSICIANS GROUP

TRISH A FONTANA
XXX-XX-3849

PLEASE RETURN ON DAY OF SCHEDULED APPOINTMENT

Appointment Date and Time 6-11-13 11:15 am

X Was Examined Report will be sent by _____

_____ Was Not Examined Because:

_____ Appointment Rescheduled For (date) _____

_____ No Show

_____ Other _____

If the examination was not done and a new appointment has not been scheduled, please return all authorization material.

This sheet MUST be on TOP *This sheet MUST be on TOP*

Return MAIL or FAX Cover Sheet

IMPORTANT: THIS SHEET MUST BE ON TOP OF YOUR RESPONSE. If you are required to return your own cover sheet, please place it under this one.

From: AMCE PHYSICIANS GROUP
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263878273
022774095
BBZZC1

CE - DMAF

RQID:022774095BBZZC101 SITE:S67 DR:S
SSN:197563849 DOCTYPE:0002 RF:D CS:ae55

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

BUREAU OF DISABILITY DETERMINATION
POST OFFICE BOX 2500
GREENSBURG, PENNSYLVANIA 15605-2500

FROM GREENSBURG CALL: 724-836-5100
ALL OTHER AREAS CALL: 800-442-6018
TTY USERS CALL: 711
FAX: *Use enclosed FAX Cover Sheet*

BDD SERVICE INVOICE

TDN: 0227744095

AUTHORIZED BY: M. Servello/JUS
OBLIGATED DATE: 05/29/13

PROVIDER TO BE PAID: (COMPLETE IF BLANK)

AMCE PHYSICIANS GROUP
PO BOX 460
HOOPER UT 84315

CLAIMANT NAME, ADDRESS AND SSN:

TRISH A FONTANA
3130 GLENDALE AVENUE
PITTSBURGH PA 15227
XXX-XX-3849

Federal ID Number OR Provider Social Security Number: 263878273

☐ "X" this box if changes were made to preprinted Name/Address or Tax ID Number.

CODE AND TYPE OF SERVICE:	FEE
019 Internal Medicine (General) Disability Examination	$150.00

TOTAL: $ 150.00
(Provider must enter amounts.)

_____/_____
Adjudicator Signature/Date

_____
Provider Signature

We certify that the above item(s) or kind(s) of service(s) were actually rendered and that the above prices and terminology are in accordance with the BDD's Authorization for Services. Payment cannot be made for unauthorized services. Neither the claimant nor his/her health insurer may be charged any fee for these services. In submitting this invoice for payment, the provider certifies that the fees charged are not in excess of those charged private patients or Federal or other agencies in the Commonwealth for the same or similar types of services.

****
* IMPORTANT: To ensure proper payment, return this barcoded invoice. Record the *
* TDN number shown on this invoice and use it as a reference number *
* when making inquiries regarding payments or claimant information. *
* This number will appear on the statement you receive with your check. *
****

263878273

0227744095

BBZZC1
208 8/11 DMAF

EXHIBIT NO. 11F
PAGE: 3 OF 7

AMCE PHYSICIANS GROUP

MEDICAL SOURCE STATEMENT OF CLAIMANT'S ABILITY TO PERFORM WORK-RELATED PHYSICAL ACTIVITIES

NAME: Trish Fontana S.S.NO.: XXX-XX- 3849

Doctor: Please assess the claimant's ability to engage in full-time employment in a regular work setting. You should consider the combined effects of all impairments, the side effects of any medication, and the effects of symptoms (e.g., pain, fatigue, etc.) The ASSESSMENT SHOULD REFLECT MAXIMUM SUSTAINABLE PHYSICAL CAPACITY, not a median or minimum. Your opinion should be based on clinical signs and laboratory findings, NOT ON THE INDIVIDUAL'S STATEMENTS.

DEFINITIONS: Occasional – from very little up to 1/3 of an 8 hour day. Frequent – from 1/3 to 2/3 of an 8 hour day.
Capacity – Maximum Sustainable Capacity

LIFTING

No Limitation ☐

Capacity:	Frequent	Occasional
2-3 pounds	☑	☐
10 pounds	☐	☑
20 pounds	☐	☐
25 pounds	☐	☐
50 pounds	☐	☐
100 pounds	☐	☐

CARRYING

No Limitation ☐

Capacity:	Frequent	Occasional
2-3 pounds	☐	☐
10 pounds	☑	☐
20 pounds	☐	☑
25 pounds	☐	☐
50 pounds	☐	☐
100 pounds	☐	☐

Supportive medical findings, if not otherwise included in report:
Lifting heavy objects exacerbates sciatica

STANDING AND WALKING

No Limitation ☐

Capacity (cumulative in 8-hour day):
- ☐ 1 Hour or less
- ☐ 1 to 2 Hours
- ☑ More than 2 Hours but less than 6 Hours; How many? 4
- ☐ 6 Hours or more
- ☐ Hand-held assistive device required for: ☐ balance; ☐ ambulation; ☐ other _____

Supportive medical findings, if not otherwise included in report:
Prolonged standing exacerbates sciatica

SITTING

No Limitation ☐

Capacity:
- ☑ Sit less than 6 Hours; How many? 4
- ☐ Sit 6 Hours
- ☐ 8 Hours with alternating sit/stand at his/her option.

Supportive medical findings, if not otherwise included in report:
Prolonged sitting exacerbates sciatica

PUSHING AND PULLING

No Limitation ☐

Consider operation of hand and/or foot controls.
- ☑ Unlimited, other than shown under lifting and carrying
- ☐ Limited in upper extremity (describe nature and degree) _____
- ☐ Limited in lower extremity (describe nature and degree) _____

Supportive medical findings, if not otherwise included in report:

BB ZZ CL

EXHIBIT NO. 11F
PAGE: 4 OF 7

AMCE PHYSICIANS GROUP

XXX-XX- 3849

POSTURAL ACTIVITIES

No Limitation ☐

How frequently can the individual perform the following activities? Please specify the nature and degree of any limitation.

	Frequent	Occasional	Never	Comments
Bending	☐	☑	☐	
Kneeling	☐	☑	☐	
Stooping	☐	☑	☐	
Crouching	☐	☑	☐	
Balancing	☐	☑	☐	
Climbing	☐	☑	☐	

Supportive medical findings, if not otherwise included in report: Unstable ankle & sciatica limit these activities

OTHER PHYSICAL FUNCTIONS

No Limitation ☑

Are the following affected by the impairment(s)? Please specify the nature and degree of any limitation.

	No	Yes	Comments
Reaching	☐	☑	
Handling	☐	☑	
Fingering	☐	☑	
Feeling	☐	☑	
Seeing	☐	☑	
Hearing	☐	☑	
Speaking	☐	☑	
Tasting/Smelling	☐	☑	
Continence	☐	☑	

Supportive medical findings, if not otherwise included in report:

ENVIRONMENTAL RESTRICTIONS

No Limitation ☑

Are the following affected by the impairment(s)? Please specify the nature and degree of any limitation.

	Comments		Comments
☐ Poor Ventilation		☐ Wetness	
☐ Heights		☐ Dust	
☐ Moving Machinery		☐ Noise	
☐ Vibration		☐ Fumes,Odors,Gases	
☐ Temperature Extremes		☐ Humidity	
☐ Chemical (Please Specify)		☐ Other (Please Specify)	

Supportive medical findings, if not otherwise included in report:

Robert Hoffman

Physician's Name (PLEASE PRINT)

Robert Hoffman

Physician's Signature

Date Last Seen June 11, 2013

June 11, 2013

Date

DD-168 Rev. 6/10 Commonwealth of PA/Bureau of Disability Determination

Accurate, Timely and Superior Evaluations

Physical Disability Evaluation

Name:	Trish A. Fontana
DOB:	6/2/1967
Age:	46
Gender:	Female
Physician's Name:	Robert Hoffman, M.D.
Date:	6/11/2013
Location:	Pittsburgh, Pennsylvania
Case #:	BBZZC1

IDENTIFICATION DATA: The claimant, a 46 year old female, was driven to the clinic by her husband. She was not in any acute distress nor did she have an assistive device. She identified herself with a Pennsylvania driver's license.

INTERPRETER'S NAME: None required.

CHIEF COMPLAINTS:
1. Left ankle fracture
2. Herniated disc lumbar spine
3. Herniated disc cervical spine

REVIEW OF RECORDS:
1. SSA-368 form.
2. MR exams of the ankle dated October 29, 2010 and June 30, 2010.

HISTORY OF PRESENT ILLNESS: 1. The patient initially injured her left achilles tendon in early 2010 and she had surgery for this injury in April of 2010, but she had no improvement. Subsequently, it was found that she actually had a fracture of her left ankle which was treated conservatively over the years with several orthopedic boots. Currently, she's able to manage while using a left ankle brace and the pain has diminished considerably. 2. Ruptured lumbar disc. The patient had the acute onset of sciatica in her right leg on June 6, 2011. An MR found that she had a ruptured lumbar disc and she underwent surgery on June 11, 2011. She has had residual sciatica in both lower extremities since the surgery. 3. The patient had the relatively acute onset of neck pain in April of this year and an MR study showed she had two herniated discs in her cervical spine.

ACTIVITIES OF DAILY LIVING: The patient lives with her husband. She is able to drive. She bathes and dresses herself and does food preparation, and light housework at home. She occupies her time mostly with taking care of her pet dog.

CURRENT MEDICATIONS: Include Ibuprofen and Vicodin PRN.

SOCIAL HISTORY: The patient does not drink alcohol, she smokes a half a pack of cigarettes per day, and she does not use illicit drugs.

PAST MEDICAL HISTORY: Surgeries as per HPI. In addition, she had pilonidal cyst surgery in 1985 and surgery on her right hand in 1995. She has not had any medical hospitalizations.

FAMILY HISTORY: Not relevant to the claimant's stated disability.

REVIEW OF BODY SYSTEMS:

HEENT: Patient wears glasses for myopia.
CARDIOVASCULAR: No complaints.
RESPIRATORY: No complaints.
GASTROINTESTINAL: Said she gets stomach upset after taking a lot of Ibuprofen.
GENITOURINARY: No complaints.
ORTHOPEDIC: As per HPI.
NEUROLOGICAL: As per HPI.

PHYSICAL EXAMINATION / SPECIFIC FINDINGS:

Vital Signs:

Height:	5' 1"	(without shoes)
Weight:	154 lbs.	(without shoes)
Blood Pressure:	120/90	
Pulse:	64	
Respirations:	10	

Eyes: Pupils equal and reactive. Normal fundoscopic exam.

Snellen Eye Test:

With Glasses:	Right: 20/25	Left: 20/30
Without Glasses:	Right: 20/40	Left: 20/30

Ears/Nose/Throat: Hearing was adequate; teeth were in adequate repair, upper area was clear.

Neck/Nodes: No evidence of cervical adenopathy or thryomegaly.

Pulses: Adequate radial and pedal pulses, no edema, or varicosities.

General appearance and observations: The patient was a pleasant female in no acute distress, alert and oriented times three. She arose from the chair in the waiting room and exam room without effort and got on and off the exam table without complaint. She rose from supine without assistance or complaint. Grip was 5/5 bilaterally.

Coordination/Station/Gait: The patient did not perform heel walking. She could only do heel toe walking for a few steps and was quite unsteady while doing this. She could not bend or squat. Balance was intact. She did not use an assistive device.

Straight Leg Raise Test: Was positive at 45 degrees bilaterally while sitting and supine.

Motor Function: Good strength in the upper extremities bilaterally, 5/5 wrist, elbow, and shoulders. Good strength in the right lower extremity, 5/5 ankle, knee, and hip. In the left lower extremity there was 5/5 strength in the knee and hip, but 3/5 strength in the left ankle.

Range of Motion: Range of motion in the cervical and lumbar spine was markedly diminished. There was only about ten degrees of flexion and extension in both areas. Patient had full range of motion in both thumbs, wrists, elbows, and shoulders. Full range of motion in the right ankle, knee, and hip. Full range of motion in the left knee and hip, but range of motion in the left ankle was decreased in all directions. She wore a brace on her left ankle.

Cardiovascular: Heart without murmurs, gallops, or rubs.

Respiratory: Normal breath sounds without wheezing.

Neurological: Cranial nerves are normal. There was a decreased left patellar deep tendon reflex. Sensory exam disclosed as there was decreased sensation to pin prick in the right big toe and medial aspect of the dorsal surface of the left foot. Romberg and Babinski were negative.

Myalgias: There were no trigger points.

Skin: Normal.

Allergies: Include Penicillin and Morphine (hives).

DIAGNOSIS AND PROGNOSIS: 1. Left Achilles and ankle injury. This appears to have recovered as much as it can be expected to. She has no further pain, but does have some limited strength and range of motion and will require a brace. 2. Ruptured lumbar disc. The patient does not have severe sciatic pain, but continues to have mild sciatica and residual neurologic symptoms after her surgery. 3. Cervical herniated disc. Patient has pain and stiffness in her cervical spine and prognosis is uncertain at this time.

FUNCTIONAL ASSESSMENT: Can be found in the medical source statement submitted separately.

Robert Hoffman, M.D.
License: MD-022667E